Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125042	A. BUILDING: _____ B. WING _____	10/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAHU CARE FACILITY	1808 SOUTH BERETANIA STREET HONOLULU, HI 96826

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4 000	Initial Comments A re-licensure survey was conducted by the Office of Health Care Assurance from 10/22/19 to 10/28/19. The facility was found not to be in compliance with Title 11, Chapter 94.1. Nursing Facilities.	4 000		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to accurately document the use of compression stocking for Resident (R)73. As a result of this deficient practice, miscommunication between the use of the intervention between staff and the physician could subject R73 to the use of a diuretic and at greater risk for further health complications. Findings Include:	4 105	1. R73 was remeasured for compression stocking. R73 is now agreeing to wear the new size of compression stocking. Licensed Nurses were in-serviced on 10/29/19, 10/30/19 and 11/12/19 of the importance of accuracy of documentation in resident□s medical records. 2. Reviewed all resident charts and	11/23/19

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/23/19

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4 105	Continued From page 1 R73 was observed with no compression stockings applied on fourteen occasions on 10/22/19, 10/23/19, and 10/24/19. Staff endorsed the treatment administration record (TAR), documenting the application and removal of the compression stockings for R73 as an intervention for edema affecting the right leg. On 10/24/19 at 01:45 PM, conducted an interview with Registered Nurse (RN)1 in which the discrepancy between the surveyor observation and documentation was shared with RN1. RN1 acknowledged the TAR documentation does not accurately portray the effectiveness of the compression stocking, R73 refusal to use the compression stocking, or the actual application of the compression stocking.	4 105	verified applications of special ordered treatment intervention(s) no other residents were identified. 3. A) The Stop and Watch form will be utilized for direct resident care staff to use to report changes in condition to licensed staff. B) Licensed nurse will document accurately in resident□s treatment record 1. Use or non-use of prescribed treatment intervention(s). C) Nursing Supervisors will review resident records for accuracy of resident treatment records weekly X 4 weeks, then complete monthly reviews. 4. Nursing Supervisors will discuss results of their audits to DON and/or designee and submit data at the Quarterly Quality Assurance Performance Improvement Committee Meetings.	
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility;	4 115		11/23/19

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4 115	Continued From page 2 This Statute is not met as evidenced by: Based on observation, record review (RR), and interview, the facility's Certified Nurse Aide (CNA) 1 failed to treat resident (R) 64 with dignity and respect by calling her a "Feeder." Findings Include: On 10/22/19 at 12:03 PM, CNA1 was in R64's room (219C) and discussing the resident's gastrostomy tube (G-tube) feeding with surveyor. It was during the course of the discussion when CNA1 referred to R64 as a "Tube Feeder." There were other residents present in the room at the time. It was then discussed with CNA1 that calling a resident a "Feeder" may not be appropriate due to respect and dignity for the resident. CNA1 acknowledged she understood. On 10/22/19 at 12:18 PM, outside the dining/activity room by the nurse's station on the second floor, CNA1 was speaking with surveyor when she stated and gestured towards the dining room to surveyor stating she was going to assist with the "Feeders." On 10/22/19 at 12:50 PM, interview with Nursing Supervisor (NS) 2 who stated she was unaware that calling residents who require assistance with their meals "Feeders" is inappropriate. NS2 queried surveyor what they should call these residents who require assistance with their meals. NS2 was informed one option maybe is to say residents who need assistance with their meals. On 10/23/19 at 01:45 PM, RR showed R64 was admitted to the facility on 08/28/19 with diagnoses of: Aspiration Pneumonia, Respiratory Failure,	4 115	1. The facility staff will respect, protect and promote the rights and dignity of R64 in a manner that improve enhancement of his/her quality of life. 2. The facility staff will perform in a manner that delivers enhancement of quality of life, protecting the rights and dignity of all other residents residing in the facility. 3. a) CNA□s, Licensed Nurses, and Activities Staff were in-serviced regarding resident rights and delivery of care that promote enhancement of quality of life on 10/29/19, 10/30/19, and 11/12/19. b) Nursing Supervisors will monitor during regular work day random direct resident care interactions and discuss of any use of incorrect terminology, monitoring as follows: weekly for 8 weeks, monthly for three (3) months, then quarterly. c) Additional one-to-one training will be provided as needed to individual staff to ensure understanding of terminology. 4. a) Each Nursing supervisor will provide data of their findings from monitoring staff at the specific intervals as well as any data regarding one-on-one individual training and/or discussion to DON and/or designee on a monthly basis. b) DON and/or designee will report the results of the audit at the Quarterly Quality Assurance Performance Improvement Committee Meetings.	

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4 115	Continued From page 3 Dementia without Behavioral Disturbance, Alzheimer's Dementia, Gastrostomy, Hypertension, Muscle Weakness, Malaise, Epilepsy. RR showed R64 has a G-tube through which she gets her medications and nutritional needs.	4 115		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to: 1) ensure resident (R)70 receives the correct physician's order for fluid consistency resulting in the resident coughing/choking; 2) ensure R73 received the care in accordance with the care plan to address edema; and 3) ensure R71 received the necessary care to prevent infections of pressure ulcers to achieve the highest most practicable level of well-being.	4 136	#1) 1. a)R70, Physician order was verified/reviewed and meal card has been updated to reflect the nectar thick liquid consistency for resident R70. b)R70 was on 24 hour report to monitor for possible aspiration risk by nursing staff until speech therapy evaluation is completed. c) On 10/25/19, a memo was sent to	11/23/19

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4 136	Continued From page 4 Findings Include: 1) R70 was admitted to the facility on 07/13/18, with a diagnoses of: stroke with hemiparesis or hemiplegia, emphysema, intermittent asthma, and interstitial lung disease. A speech therapist consultation on 07/31/18, identified R70 at risk for aspiration. However, the facility's kitchen staff, unit staff, dietary staff and NS1 were not aware R70 was not receiving a nectar thick fluid consistency as ordered since 07/18/19. On 10/22/19 at 11:47 AM, observed R70 in the 3rd floor dining area during lunch, drinking independently. R70 was seated at a table with one other resident which was being assisted with lunch by certified nurse's aide (CNA)2. The surveyor was positioned approximately 2 feet away from R70, with a clear view of the contents of R70's tray. R70 received a lunch tray that contained 3 separate cups of liquid. The cups contained different types of fluid. The fluid consistency appeared to be: a pre-filled thickened water; a cup of non-thickened water; and a brown mug filled with non-thickened coffee. Later confirmed in an interview with Registered Dietician (RD)1, the fluid on R70's tray consisted of 4 ounces(oz) of nectar thick fluid, 4 oz of regular (non-thickened) consistency that is to be mixed together for the appropriate consistency for R70 and confirmed R70 has not been receiving the ordered fluid consistency since 07/18/19. Observed R70 coughing/choking after drinking the clear fluid from the regular cup continuously throughout lunch. CNA2 was seated at the same table, did not inspect R70's food, drink or diet card and continued to assist another resident with lunch. While the surveyor observed R70	4 136	the nursing department and dietary department in regards to the action plan for handling residents diets and a process to check all diet trays against the meal card before serving tray to the residents. Any new orders will be phoned-in to dietary department and a copy of the physician s order will be placed in the dietary communication book. d)Speech therapy evaluation for R70 was completed on 11/1/19 with a new physician's order to honey thick liquid. Meal card has been updated. 2. An audit was conducted for 61 residents who are on therapeutic diets ordered by physician and compared with the meal card. There is only one (1) resident identified (R70) who was given an incorrect consistency based on their meal card ordered. Meal card updated on 10/25/19 and another update to meal card on 11/1/19 with the new physician s order. Another audit was conducted on 10/28/19 for all residents with physician-ordered diets to make sure all orders are matching. 3. a) On 11/12/19, Staff were in-serviced on new process for handling physician orders, dietary terminology and communication from nursing department to dietary department. b) Food Service staff and Nursing staff will check meal card for proper diets of residents during mealtime service.	

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4 136	Continued From page 5 coughing/choking, the Nursing Supervisor (NS)1 entered the dining area and observed the surveyor monitoring R70. R70 started to cough/choke after drinking the non-thickened water. Later, observed NS1 removing the coffee and the diet card from R70. NS1 confirmed the consistency of the coffee was not thickened and should be thickened. Reviewed the diet card with NS1, the diet card stated, "Fruit juice: 3 each Nectar thick water and 1/2C (cup) thin liquids by Nursing". However, a review of the October 2019 Physician's Order sheet documented the fluid order as "Nectar Thick Only." Further record review for R70 noted a nutrition assessment by RD2 which documented, ".....downgrade liquids to nectar thick liquids...Family also states kitchen is mincing meats, resident prefers meat mech (mechanical) soft as it states in diet order. Sent reminder to kitchen." On 07/18/19, RD2 completed a physician telephone order. The physician verified the telephone order as "Nectar Thick Only" fluid consistency. Additionally, R70's comprehensive care plan reflected the change to nectar thick consistency on 07/18/19. The Director of Nursing (DON) and NS1 both confirmed there was a discrepancy with the fluid consistency delivered to R70, the diet card (Fruit juice: 3 each Nectar thick water and 1/2C thin liquids) and the physician's order (nectar thick only). DON1, RD1, NS1, Unit Clerk (UC)1, Registered Nurse (RN)1 and Dietary Cook Supervisor (DCS)1 were unable to provide documentation of the change from "nectar thick water and 1/2C thin liquids" to "nectar thick only" fluid consistency for R70 on 07/18/19. DON1 and	4 136	c) An audit will be conducted by Lead cook/Food Service Director and/or designee for residents who are on therapeutic diets on a weekly basis for the next 6 weeks, monthly for the next three (3) months and quarterly thereafter. 4. Food Service Director/Lead Cook and/or designee will report the results of therapeutic diet audits at the Quarterly Quality Assurance Performance Improvement Committee Meetings. #2) 1. R73 was remeasured for compression stocking. R73 is now agreeing to wear the new size of compression stocking. Licensed Nurses were in-serviced on 10/29/19, 10/30/19 and 11/12/19 of the importance of accuracy of documentation in resident□s medical records. 2. Reviewed all resident charts and verified applications of special ordered treatment intervention(s) no other residents were identified. 3. A) The Stop and Watch form will be utilized for direct resident care staff to use to report changes in condition to licensed staff. B) Licensed nurse will document accurately in resident□s treatment record 1. Use or non-use of prescribed treatment intervention(s). C) Nursing Supervisors will review resident records for accuracy of resident	

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4 136	Continued From page 6 NS1 confirmed R70 has not received the changed fluid consistency since the order date of 07/18/19. The facility's failure to provide the correct fluid consistency and lack of staff awareness of what the resident should be receiving have contributed to R70's coughing/choking continuously during lunch on 10/22/19. 2) An initial observation of R73 on 10/22/19 at 09:24 AM, noted R73 sitting in a wheelchair with redness and edema to the right leg. resident (R)73 was admitted on 01/12/18, with a diagnoses of hemiplegia or hemiparesis on the right side. Observed R73 on fourteen (10/22/19 at 09:24 AM, 11:30 AM, 01:44 PM, 02:35 PM; 10/23/19 at 09:14 AM, 11:00 AM, 01:32 PM, 02:56 PM; 10/24/19 at 08:29 AM, 09:14 AM, 10:17 AM, 11:40 AM, 01:49 PM, 03:37 PM) occasion in which R73 was sitting upright in a wheelchair with no compression stocking applied to the right leg for edema. On 10/23/19 at 01:49 PM, a record review R73's October 2019 comprehensive care plan (initiated on 01/01/19) addresses R73's edema, secondary to cerebrovascular accident (CVA), with an intervention to use a compression stockings/TED hose on the right leg. Additionally, R73 has a current physician order (initiated on 01/01/19) for staff to provide compression stocking before getting out of bed in the morning and remove when sleeping at night for edema. Further record review of the Treatment Administration Record (TAR), staff endorsed the application and removal of the compression stocking for R73. On 10/22/19, 10/23/19, 10/24/19, staff endorsed the	4 136	treatment records weekly X 4 weeks, then complete monthly reviews. 4. Nursing Supervisors will discuss results of their audits to DON and/or designee and submit data at the Quarterly Quality Assurance Performance Improvement Committee Meetings. #3) 1. Director of Nursing, MDS/RAI Nurse Coordinator in consultation with the Medical Director will ensure that R71 who has pressure ulcer/pressure injuries receives necessary treatment and services to promote healing, prevent and manage infection and prevent new pressure ulcer/injury from developing. R71 visited the Infectious Disease Physician on 11/13/19. On 11/20/19, R71 has an appointment at the Wound Clinic to see the Wound Specialist Physician and collaborate further treatment with the Infectious Disease Physician. Nursing Supervisors, MDS/RAI Nurse Coordinator, Wound Nurse, Licensed Nurses were in-serviced in regards to skin assessments, Braden scale, residents who present with pressure ulcer/injury and their role in Antibiotic Stewardship on 10/29/19, 10/30/19, and 11/12/19. 2. Residents are monitored regularly as follows: 1. On admission, and weekly skin	

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4 136	Continued From page 7 application of the compression stocking on the TAR, the surveyor observation during these times found the resident without compression stocking. On 10/24/19 at 01:45 PM, interviewed Registered Nurse (RN)1 regarding the use and documentation of compression stockings for R73. RN1 stated R73 should have a compression stocking applied in the morning and removed it at night because R73 has edema in the right leg. The treatment record was reviewed with RN1. RN1 confirmed that a check mark on the TAR indicates the compression stocking were applied and removed. The discrepancy between the observation and documentation was shared with RN1. Inquired with RN1, how does staff accurately report the use of the compression stocking to the physician. RN1 stated the TAR is used to communicate the use of the compression stocking and staff does not normally document the use of the compression stocking in the progress note. RN1 acknowledged the TAR documentation does not accurately portray the effectiveness of the compression stocking, R73 refusal to use the compression stocking, or the actual application of the compression stocking. A review of R73's annual history and physical conducted on 02/21/19 stated ".....still markedly swollen legs-despite TEDs (compression stocking).....- strongly consider diuretics= pt (patient) c (with) mult (multiple) comorbidities/ advanced age/ debility- patient's condition is very unstable and needs very close monitoring as very high risk outcomes esp (especially) DVT (deep vein thrombosis)/ pulmonary embolus, hypo-hypertension/ syncope/ cardiovascular compromise." 3) Resident (R)71 was admitted to the facility on	4 136	assessment. 2. Braden scale completed on admission and weekly X4 weeks, if change in skin condition occurs, and quarterly. 3. Wound Nurse conduct weekly assessments with residents with pressure ulcer/injury and updates assessments, physicians and documents in resident□s medical records. 4. Wound Nurse consults with Wound Specialist at least bi-weekly and confers with Specialist regularly when any concerns arise. 5. Nursing Supervisors and License nurse continue to participate in Antibiotic Stewardship program to ensure that residents are monitored and meet the criteria for antibiotic use. 3. DON, Nursing Supervisors and MDS/RAI Nurse Coordinator will monitor skin/wound assessments, Braden scale results, and provide interventions when risk factors are present. Nursing Supervisors will review the Antibiotic Stewardship Forms and only residents meeting the criteria for infection will be referred to Primary Care Physician for Orders. 4. DON, Nursing Supervisors and MDS/RAI Nurse Coordinator will meet regularly to discuss each case individually. Data obtained from reviews will be formulated into a report. Director of Nursing and/or designee will reports the results of data collected at the	

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4 136	Continued From page 8 06/06/17 from an acute care hospital. R71's diagnoses include: nontraumatic subdural hemorrhage, unspecified; paraplegia, complete; personal history of pulmonary embolism; acute hypoxic respiratory insufficiency; neurogenic bladder requiring foley catheter; and diabetes mellitus, type 2. R71 was admitted to the facility for hospice care. R71 was admitted to the facility with an unstageable pressure injury to the coccyx (2.5 x 3 cm) which has currently been assessed as a Stage 4. R71 also has a Stage 4 pressure injury to the right ischial tuberosity and a Stage 4 pressure injury to the left ischial tuberosity which was facility acquired. A record review was done on 10/23/19 at 01:31 PM. The Minimum Data Set with an assessment reference date of 10/03/19 found R71 yielded a score of 15 (cognitively intact) when the Brief Interview for Mental Status was administered. R71 is totally dependent on staff (two plus persons physical assist) for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) and has functional limitation in range of motion bilaterally to the lower extremities. R71 is also noted to have three, Stage 4 facility acquired pressure injuries. On 10/22/19 at 09:40 AM an interview was conducted with R71. R71 reported that she was in pain due to the mattress, the resident reported initially an air mattress was provided but found that it was uncomfortable and requested a different mattress. R71 reported not participating in activities as she can only sit in the chair for one hour because of her wounds. On the morning of 10/24/19 another interview was conducted with	4 136	Quarterly Quality Assurance Performance Improvement Committee Meetings.	

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R71. Inquired whether she is aware that the air mattress can help to heal her wounds, R71 responded she is aware but finds that the air mattress is not good for her body. R71 reported staff respond promptly to provide peri-care for bowel incontinence and also reported observing staff members washing their hands while providing care. R71 reported that "sometimes" she refuses dressing change. Further inquired what she needs to do to improve her wounds, she responded to turn every two hours; however, prefers to be on her back. R71 is aware that her wounds are infected.

On the morning of 10/25/19 the facility provided the "Pressure Ulcer Skin Assessment" which documents the onset of the pressure injuries to the right gluteal fold and the left buttock on 12/04/17. The pressure injuries were assessed at Stage 1. The Treatment Record documents in 12/13/17 the injuries to the left and right buttock were now assessed as Stage 2. The pressure injury to the coccyx was assessed as a Stage 4. In January 2018, the Registered Dietitian (RD) documents the pressure injuries to the left and right buttocks was assessed as Stage 3.

A review of the Dietitian notes found documentation of resident's poor intake with some weight loss. Also noted are the supplements that were being provided to the resident to facilitate wound healing (multi-vitamins, glucerna, protein enriched liquids). The physician order for the month of October 2019 notes R71 is provided with Arginaid (120 ml) twice daily and Promod liquid (2 ounces) at breakfast and one ounce at noon to aide in wound healing.

A review of the Wound Specialist (WS) notes R71

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4 136	Continued From page 10	4 136		

has declined the use of an air mattress, bruising to wound related to resident's insistence of sitting in a shower chair, loose stools possibly related to use of antibiotics and an incident of leaking foley catheter. The WS documented on 10/17/19, R71 continues to decline the use of an air mattress and continues to request showers. The WS recommends a referral to an infectious disease physician due to recurrent infections. A wound culture was ordered on 10/24/19.

The Pharmacist's medication regimen review (MRR) found documentation of R71 on antibiotics due to wound infections, dating back to 05/15/18. R71 was noted to receive antibiotics in May 2018, June 2018, July 2018, August 2018, February 2019, April 2019, May 2019, July 2019, and August 2019. The cultures ranged from e. coli, morganella, staph aureus, enterococcus, and MRSA. The MRR for September 2019 found doxycycline and levofloxacin was prescribed. The wound culture found MRSA, pseudomonas and e. faecalis.

A review of the facility's "Quality Assurance Tool" for assessing unavoidable pressure ulcers prepared by the Director of Nursing (DON) and signed by R71's physician notes the following, based on the measures identified, care planned and implemented, the interventions are sufficient and reasonable to prevent the formation of pressure ulcer; however, the measures were not successful in preventing the formation of pressure ulcers. Therefore, the formation of pressure ulcers were unavoidable. The document was signed on 09/02/19 by the Director of Nursing (DON) and the physician in October (the signed date is illegible).

On 10/24/19 at 08:32 AM an interview was done

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	125042	A. BUILDING: _____ B. WING _____	10/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAHU CARE FACILITY	1808 SOUTH BERETANIA STREET HONOLULU, HI 96826

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 11	4 136		

with the WS. The WS reported there are many components to the prevention and healing of R71's pressure injuries. The WS stated R71 refuses air mattress, continues to request showers (shower chair causes bruising and the resident requires use of Hoyer lift for transfers) and favors laying on her back. Further queried what causes the infections to the pressure injuries. WS acknowledged that the infections does not help with the wound healing; however, has observed good infection control techniques during wound care by facility staff. The WS stated maybe the bacteria is in the water or the resident's family brought it in while visiting. The WS could not identify the source of the bacteria. Further inquired whether the infection control consultant has been involved in R71's care, the WS responded not being aware if the facility has an infection control consultant/preventist. The WS reported the most important factor is for R71 to help them heal the wounds. The WS reported R71 will be referred to an infectious disease physician.

On 10/24/19 at 01:30 PM an interview was conducted with Nursing Supervisor (NS)2. NS2 reported R71 graduated from hospice sometime in March/April 2019 after receiving hospice services for almost two years. Inquired whether causal factors contributing to R71's infections were assessed. NS2 responded maybe it is from the water or the food as the staff demonstrates good infection control techniques. The NS2 deferred to the DON.

On 10/24/19 at 01:44 PM an interview was conducted with the DON. The DON reported infections are suspected when there is an odor or the wound healing is stalling. Although the resident does not present with a fever or pain, a

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4 136	Continued From page 12 wound culture is taken. Inquired whether the facility's infection control consultant was consulted. The DON replied the consultant is aware; however, has not said much. The DON also expressed concern whether the water source has been a contributory factor to the wound infections and would like to request evaluation of the facility's water. On the morning of 10/25/19, the DON report R71 has an appointment with the infectious disease physician. The DON also reported consideration of limiting the staff members to perform R71's dressing change to two nurses for consistency.	4 136		
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observation, record review and interview with staff member, the facility failed to develop a comprehensive person-centered care plan for 1(Resident 31) of 18 residents in the sample. Resident 31 had an incomplete care plan to address his activities of daily living. Findings Include: Resident (R)31 was admitted to the facility on 05/09/19 for respite services. Diagnoses include: unspecified atrial fibrillation; dilated	4 174	1. R31 Careplan and interventions were completed on 10/25/19 by NS2. 2. A review of all resident Careplans and interventions were completed by NS2, NS3 and DON all have been completed 11/15/19. 3. Nursing Supervisors, MDS/RAI Nurse Coordinator and/or designee will ensure completeness of individualize Careplans and interventions within the first week of	11/23/19

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4 174	Continued From page 13 cardiomyopathy; unspecified hearing loss; and benign prostatic hyperplasia without lower urinary tract symptoms. On 10/22/19 at 01:49 PM, R31 was observed in bed, he was unshaven and had a scruffy beard. A review of the quarterly Minimum Data Set with assessment reference date of 08/16/19 notes R31 is independent for decision making regarding tasks of daily life. The resident was also coded to reject care, one to three days during the assessment period. R31 requires limited assistance with one personal physical assistance for personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands). A review of R31's care plan with an onset date of 05/09/19 notes the following goals for the resident's activities of daily living (ADL): resident's ADL needs will be met through next 90 days; promote resident's highest ADL functioning level in the next 90 days; and resident will show improvement with self-ADL performance in the next 90 days. The interventions for self-performance level and the support required for R31 to complete ADLs were incomplete. Further review found documentation in the resident's care plan for psychosocial well-being/mood/behavior an entry dated 06/13/19 that R31 is combative and resistive to hygiene care. R31 also refused showers most of the time but was agreeable to bed baths/wipe down. On 10/25/19 at 08:29 AM, concurrent review of the care plan and interview was done with Nursing Supervisor (NS)2. NS2 confirmed R31's care plan was incomplete. The level of	4 174	admission to the facility. An audit by either the Nursing Supervisors, MDS/RAI Nurse Coordinator, Director of Nursing, and/or designee will be done monthly on all new admissions, and on quarterly reviews. 4. DON, Nursing Supervisors and/or designee will review audits and data collected and report the results of the audit at the Quarterly Quality Assurance Performance Improvement Committee Meetings.	

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4 174	Continued From page 14 self-performance and support were not indicated for the following areas: bed mobility; transfers; dressing; grooming/personal hygiene; locomotion; bathing; toilet use; and ambulation. The onset date of this care plan was documented as 05/09/19. Subsequent to review of the care plan with NS2, on 10/25/19 at 08:38 AM the NS provided a copy of R31's care plan with completion of the interventions identifying R31's need for support to complete all areas of ADLs.	4 174		